



BRYN ATHYN COLLEGE

# Student Health Center Health Information Packet

For All Students

BRYN ATHYN COLLEGE HEALTH SERVICES | BOX 915, 900 CAMPUS DRIVE, BRYN ATHYN PA 19009

# BRYN ATHYN COLLEGE

## Health Information Instructions and Checklist

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Packet is required of all students

### Packet Checklist

- Student Information Page
- Health History Questionnaire Part 1 (to be filled out by student and reviewed by physician)
- Health History Questionnaire Part 2 (to be filled out by student and reviewed by physician)
- Hippa/Ferpa/Insurance Form
- Copy of Insurance Card
- Immunization Record Form (to be reviewed and signed by physician)
- Health Services TB Questionnaire Part 1 (to be filled out by student and reviewed by physician)
- Health Services TB Questionnaire Part 2 (to be filled out by student and reviewed by physician)
- Physical Form Part 1 (to be completed by physician)
- Physical Form Part 2 (to be completed and signed by physician)

### Instructions

Once the Health Information Packet has been reviewed and completed, it should be emailed, faxed, or mailed to the Student Health Center. **Fall freshmen** must return the completed health form **by July 1st** OR **four weeks** before the start of the term for winter and spring terms and Graduate programming.

**Email** (*preferred method*):  
HealthCenter@brynathyn.edu

**Fax:** 267-502-6024

**Mail to:** Director of Health and Wellness  
Bryn Athyn College, PO Box 915  
900 Campus Drive, Bryn Athyn, PA 19009

- **Keep a COPY** of this form, and any attachments for your records
  - Submission of this form is MANDATORY for all BAC students
  - **Athletes:** to participate in a sport at BAC a **COMPLETED** medical form **MUST BE SUBMITTED** to Bryn Athyn Health Services **PRIOR** to ANY NCAA tryout/participation.
- Questions? Call 267-502-6077 or email HealthCenter@brynathyn.edu

### About the Student Health Center

The Student Health Center is the primary health care facility for the College. The purpose is to provide health care services while assisting students to take responsibility for their own health and wellness. The Health Center hours of operation are available on the Health Services web page.

900 Campus Drive, Box 915, Bryn Athyn, PA 19009 | <https://www.brynathyn.edu/health>

Phone: 267-502-6077 | Fax: 267-502-6024

# BRYN ATHYN COLLEGE

## Student Information Page

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

**FAILURE TO COMPLETE THIS HEALTH FORM RESULTS IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES AND HOUSING.**

### Student Information

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_  
HOME PHONE NUMBER: \_\_\_\_\_  
STUDENT CELL PHONE NUMBER: \_\_\_\_\_  
BIRTH DATE: \_\_\_\_\_  
SEX: \_\_\_\_\_  
COUNTRY RAISED IN: \_\_\_\_\_  
COUNTRY OF BIRTH: \_\_\_\_\_

**CHECK ALL THAT APPLY:**

- Undergraduate  Graduate  Theological School
- Resident  Commuter  International  Online

- Full Time  Part Time  Auditor  Transfer
- Freshmen  Sophomore  Junior  Senior

### Emergency Contact

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTRY: \_\_\_\_\_  
HOME PHONE NUMBER: \_\_\_\_\_  
WORK PHONE NUMBER: \_\_\_\_\_  
CELL PHONE NUMBER: \_\_\_\_\_

## Health History Questionnaire Part 2

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please fill out this page and take to physical | Physician: please review during physical

### MEDICATIONS (Prescription, non-prescription, vitamins, herbal, etc.)

Medication	Dose	Times Taken Per Day

### ALLERGIES/REACTIONS

Medicine/Food/Agent	Reactions/ Side Effect

### HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

#### A. NEUROLOGICAL

- Concussion (list dates): \_\_\_\_\_
- Cerebral Palsy
- Migraines/ Headaches
- Seizure Disorders

#### B. CARDIOVASCULAR

- Fainting
- Blood Disorder
- Heart Condition (list): \_\_\_\_\_

- Blood Pressure Abnormalities
- Heart Murmur
- Chest Pain/ Discomfort

#### C. GASTROINTESTINAL

- Chronic Inflammatory Bowel Disease
- Digestive Problems (describe): \_\_\_\_\_

- Acid Reflux
- Hernia
- Gallbladder Disease
- Liver Disease

#### D. GENITOURINARY

- Urinary Tract Infections
- Kidney Stones
- Kidney Disease

#### E. INFECTIOUS DISEASES

- Chicken Pox
- Viral Hepatitis
- Infectious Mononucleosis (Mono)
- MRSA (Methicillin Resistant Staph Aureus)  
Date: \_\_\_\_\_
- Positive TB Testing  
Date: \_\_\_\_\_
- Preventative INH Treatment for Tuberculosis  
Date: \_\_\_\_\_  
Length of Treatment: \_\_\_\_\_

- HIV

#### F. METABOLIC/ ENDOCRINE

- Diabetes Type 1/ Type 2
- Thyroid Disorder
- Hypoglycemia

#### G. RESPIRATORY

- Asthma/ Sports- Induced Asthma  
Asthma Medication: \_\_\_\_\_
- Seasonal Allergies: \_\_\_\_\_
- Shortness of breath

#### H. MEN'S HEALTH

- Testicular Problems

#### I. WOMEN'S HEALTH

- Irregular Menses
- Painful Menses
- Last menstrual period \_\_\_\_\_

Health History Questionnaire  
Part 2

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please fill out this page and take to physical | Physician: please review during physical

J. PSYCHOLOGICAL OR SOCIAL

- Alcohol/ Drug Abuse Problems
- Anxiety
- Depression
- Eating Disorder
- Panic Attack
- Insomnia
- ADD/ ADHD
- Learning Disability
- Suicide Attempt
- Psychiatric Admission

K. ILLNESSES NOT LISTED ABOVE: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

L. SURGERIES AND HOSPITALIZATIONS

Dates: \_\_\_\_\_ Specify reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

M. ORTHOPEDIC HISTORY - Have You Ever Had an Injury to:

- Shoulder (describe): \_\_\_\_\_  
\_\_\_\_\_
- Elbow/Wrist/Arm/Hand (describe): \_\_\_\_\_  
\_\_\_\_\_
- Lower Leg (describe): \_\_\_\_\_  
\_\_\_\_\_
- Knee (describe): \_\_\_\_\_  
\_\_\_\_\_
- Ankle/Foot (describe): \_\_\_\_\_  
\_\_\_\_\_
- Hip/Groin (describe): \_\_\_\_\_  
\_\_\_\_\_
- Back/Ribs (describe): \_\_\_\_\_  
\_\_\_\_\_

Neck (describe): \_\_\_\_\_  
\_\_\_\_\_

Physical Disability (describe): \_\_\_\_\_  
\_\_\_\_\_

N. FAMILY HISTORY

Have any of your blood relatives had any of the following?  
High Blood Pressure

- yes  no

Heart Disease (heart murmur, hypertrophy, irregular heartbeat, Marfan's Syndrome, heart attack, stroke)

- yes  no

Diabetes

- yes  no

Non-accidental/sudden death in immediate family before age 50

- yes  no

Please explain any YES responses below: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

O. CONCUSSION HISTORY

Have you ever been diagnosed with a concussion?

- yes  no  unsure

If yes:

Number of concussions \_\_\_\_\_

Date(s) of injury: \_\_\_\_\_  
\_\_\_\_\_

How long did it take you to recover? \_\_\_\_\_  
\_\_\_\_\_

Did you lose consciousness or get "knocked out"?

- yes  no

Did you have to go to the hospital?

- yes  no

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

### Patient Privacy Rights

All services provided by the Student Health Center are strictly confidential. Medical Information cannot be released to family members without permission from the student unless the student is a threat to himself or others. Visit our website <https://www.brynathyn.edu/health> for more information about our services, or call our office at 267-502-6070.

### Students to fill out this information

## Voluntary Student Authorization to Disclose Health Information to Health Care Providers

I \_\_\_\_\_ understand that the Bryn Athyn College Health Services Clinic ("Clinic") may wish to disclose my health information to a hospital or other health care provider so that I may receive care not provided in the Clinic. While this information may be disclosed under the Family Educational Rights to Privacy Act ("FERPA") without my authorization provided that it is disclosed solely for treatment purposes, I understand that there may be possible subsequent disclosures of my health information by a health care provider for reasons unrelated to treatment. Such disclosures may not occur without my authorization. In order to address this concern, the Clinic requests my authorization in the event of such disclosures. I understand that I am not required to sign this authorization and do so voluntarily. The Clinic will not condition any health care treatment on whether or not I authorize such disclosure.

Thereby authorize the health care providers at the Clinic to disclose my protected health and treatment-related information regarding any injury or illness I may experience while I am enrolled as a part-time or full-time student at the College to any hospital, health care facility and other health care professionals for the purpose of my receiving medical treatment, emergency care, hospitalization or other health care services not provided in the Clinic, as well as for non-treatment purposes a health care provider may have (e.g., billing). It is also my understanding that I may, at any time, advise the Clinic that I revoke this authorization or choose to limit instances of disclosure. It is my responsibility to so advise the Health Services Coordinator at the Clinic in writing. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization.

I understand that my health information is protected by the Clinic under FERPA as a "treatment record" if disclosed only for treatment purposes. Once the Clinic discloses my health information to a health care provider, my information continues to be protected by the College under FERPA and by the health care providers under the Health Insurance Portability and Accountability Act ("HIPAA"). Once disclosed for non-treatment purposes, my health information will continue to be protected by the College under FERPA as an "education record" and by the health care provider under HIPAA.

Unless sooner rescinded, this authorization expires once my enrollment at the College has concluded.

I hereby agree to the above.

Student Name (please print): \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(IF UNDER 18 YEARS OF AGE)

### Health Insurance Request

All students are **required** to have health insurance. A copy of their insurance card is kept on file to help assist the health center in guiding care. It is recommended that students carry their health insurance cards at all times. Please attach a copy of your health insurance card (front and back) and a copy of your dental insurance card if you have one. This information will be used by health services during an emergency situation.

● **I have attached a copy of my insurance cards front and back (must be a current non-expired card). A copy of your insurance card can be obtained on your insurance carrier's website.**

● **I do not have health insurance and would like to explore my insurance options.**

It is required that international students purchase US insurance policies or policies that are active in the US. If you do not provide a copy of your health insurance, you may be subject to registration and housing holds as well as fines. Please let us know if you do not have health insurance we would be happy in assisting locate information on finding affordable insurance policies. The college does not have a policy that we automatically enroll students in.

PLEASE INFORM US OF ANY CHANGES. STUDENTS SHOULD CARRY A COPY OF ALL INSURANCE INFORMATION ON THEIR PERSON.  
STUDENT ATHLETES ARE REQUIRED TO HAVE MEDICAL INSURANCE.

## Immunization Record Form

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

**REQUIRED IMMUNIZATION INFORMATION-ALL STUDENTS BORN AFTER 1956 MUST PROVIDE THIS INFORMATION**

Vaccines	Dates Given/Performed	Requirement
MMR	Dose 1 ____/____/____ <small>MM DD YYYY</small> Dose 2 ____/____/____ <small>MM DD YYYY</small>	<ul style="list-style-type: none"> <li>• 2 doses of MMR</li> <li>• Minimum of 4 weeks between doses</li> <li>• First dose given after 1st birthday</li> <li>• Second dose after age 4</li> </ul>
Individual Vaccines: Measles Mumps Rubella	<p><b>OR</b> <b>Measles</b> <b>OR</b></p> <p>Dose 1 ____/____/____      Dose 2 ____/____/____ <small>MM DD YYYY</small>      <small>MM DD YYYY</small></p> <p><b>Mumps</b></p> <p>Dose 1 ____/____/____      Dose 2 ____/____/____ <small>MM DD YYYY</small>      <small>MM DD YYYY</small></p> <p><b>Rubella</b></p> <p>Dose 1 ____/____/____      Dose 2 ____/____/____ <small>MM DD YYYY</small>      <small>MM DD YYYY</small></p>	<ul style="list-style-type: none"> <li>• 2 doses of each individual component (2 measles, 2 mumps, 2 rubella)</li> <li>• Minimum of 4 weeks between doses</li> <li>• First dose given after 1st birthday</li> <li>• The second dose is recommended after age 4</li> </ul>
Positive blood test showing immunity	<p><b>OR</b> <b>Attach laboratory report</b> <b>OR</b></p> <p>Measles titer date ____/____/____      Result _____ <small>MM DD YYYY</small></p> <p>Mumps titer date ____/____/____      Result _____ <small>MM DD YYYY</small></p> <p>Rubella titer date ____/____/____      Result _____ <small>MM DD YYYY</small></p>	<ul style="list-style-type: none"> <li>• Positive titers</li> </ul>
Meningococcal (meningitis) Group A	<p>____/____/____      ____/____/____      <b>Check One</b></p> <p><small>MM DD YYYY</small>      <small>MM DD YYYY</small></p> <p><input type="radio"/> Menactra</p> <p><input type="radio"/> Menveo</p>	<ul style="list-style-type: none"> <li>• If initial dose is given under 16 years of age, two doses are required. If initial dose is given at 16 years of age or older, one dose is required.</li> </ul>
Meningococcal Group B (required for residential living)	<p><b>MenB-4C (Bexsero)</b></p> <p>Dose 1 ____/____/____      Dose 2 ____/____/____ <small>MM DD YYYY</small>      <small>MM DD YYYY</small></p> <p><b>OR</b></p> <p><b>MenB-FHbp (Trumenba)</b></p> <p>Dose 1 ____/____/____      Dose 2 ____/____/____ <small>MM DD YYYY</small>      <small>MM DD YYYY</small></p> <p>Dose 3 ____/____/____ <small>MM DD YYYY</small></p>	<ul style="list-style-type: none"> <li>• <b>required for residential living</b></li> <li>• 2 doses at least one month apart (for Bexsero)</li> <li>• 3 doses at 0, 2 and 6 months (for Trumenba)</li> </ul>

Varicella (chicken pox)	Dose 1 ____/____/____      Dose 2 ____/____/____ <small>MM DD YYYY</small> <small>MM DD YYYY</small>	<p><b>OR</b> <b>Date of Disease</b> <b>OR</b> <b>Titer</b></p> <p>____/____/____      ____/____/____ <small>MM DD YYYY</small>      <small>MM DD YYYY</small></p>
Tdap within 10 years	____/____/____ <small>MM DD YYYY</small>	
Hepatitis B or Twinrix (optional, but recommended)	Dose 1 ____/____/____      Dose 2 ____/____/____      Dose 3 ____/____/____ <small>MM DD YYYY</small> <small>MM DD YYYY</small> <small>MM DD YYYY</small>	<p><b>OR</b> <b>Titer</b></p> <p>____/____/____ <small>MM DD YYYY</small></p>

### Practitioners Signature Required

Clinician Name (MD/NP/PA)

Clinician Signature

Clinician Phone Number

Date

\*Acceptable Documentation in Lieu of a Provider Signature includes a copy of an up-to-date high school or university immunization record, provider-signed personal immunization records, proof of current or previous active duty (DD214) status in the US Military or International W.H.O Yellow Book showing MMR dates.

## Health Services TB Questionnaire Part 1

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

**REQUIRED! THIS SECTION MUST BE COMPLETED BY ALL STUDENTS, NOT YOUR DOCTOR.**

1. Have you ever had close contact with persons with known or active TB (tuberculosis) disease?	<input type="radio"/> Yes <input type="radio"/> No
2. Were you born or have you lived or travelled for more than one month in one of the countries listed below with a high incidence of active TB (tuberculosis) disease?	<input type="radio"/> Yes <input type="radio"/> No
3. If yes, what country? (circle the country/ countries in the list below)	
4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	<input type="radio"/> Yes <input type="radio"/> No
5. If yes, where? _____	
6. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?	<input type="radio"/> Yes <input type="radio"/> No
7. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or those abusing drugs or alcohol?	<input type="radio"/> Yes <input type="radio"/> No

- A** - Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan
- B** - Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burma, Burundi
- C** - Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China, Colombia, Comoros, Congo, Côte d'Ivoire
- D** - Dem Ppl's Rep of Korea, Dem Rep of Congo, Djibouti, Dominican Republic
- E** - Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia
- F** - Fiji
- G** - Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana

- H** - Haiti, Hong Kong, Honduras
- I** - India, Indonesia, Iran (Islamic Republic of), Iraq
- K** - Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan
- L** - Lao Ppl's Democratic Rep, Latvia, Lesotho, Liberia, Libya, Lithuania
- M** - Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Mongolia, Morocco, Mozambique, Myanmar
- N** - Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue
- P** - Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal
- Q** - Qatar
- R** - Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda

- S** - Saint Vincent/Grenadines, Sao Tome and Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland
- T** - Taiwan, Tajikistan, Tanzania, Thailand, Timor-Leste, Togo, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu
- U** - Uganda, Ukraine, United Rep of Tanzania, Uruguay, Uzbekistan
- V** - Vanuatu, Venezuela, Viet Nam
- Y** - Yemen
- Z** - Zambia, Zimbabwe



## Health Services TB Questionnaire Part 2

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

**TB SYMPTOM CHECK - THIS SECTION MUST BE COMPLETED BY A HEALTH CARE PROVIDER.**

**Does the student have signs or symptoms of active pulmonary tuberculosis disease?**  Yes  No

**If yes, check below and proceed:**

- Cough (especially if lasting for 3 weeks or longer)
- Chest pain with or without sputum production
- Unexplained weight loss
- Fever
- Coughing up blood (hemoptysis)
- Loss of appetite
- Night sweats

**Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.**

**Tuberculin Skin Test (TST)**

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, with "0". The TST interpretation should be based on mm of induration as well as risk factors.\*\*)

Date Given: \_\_\_\_\_ Date Read: \_\_\_\_\_

Result: \_\_\_\_\_ mm of induration \*\*Interpretation: positive \_\_\_\_\_ negative \_\_\_\_\_  
(MONTH/DAY/YEAR) (MONTH/DAY/YEAR)

**IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ON THE TB QUESTIONNAIRE, BRYN ATHYN COLLEGE REQUIRES YOU TO PROVIDE THE FOLLOWING:**

Interferon-based Assay TB Blood Test Quantiferon Gold Test or T-Spot <small>*Must be performed in the United States.</small>	<b>Date of blood test</b> ____ / ____ / ____ <small>MM DD YYYY</small>	<b>Attach laboratory report</b> Result _____
--	--	---

If the result of the above test is **POSITIVE**, you must provide the following:

Chest X-ray	<b>Date of X-ray</b> ____ / ____ / ____ <small>MM DD YYYY</small>	<b>Attach X-Ray report in English</b> Result _____
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- Treatment for latent TB (check one)
- Patient completed full course of treatment for latent TB.  
 Medication and dates \_\_\_\_\_  
 \_\_\_\_\_
  - Patient did not complete treatment for latent TB.  
 Reason \_\_\_\_\_  
 \_\_\_\_\_

## Physical Form Part 1

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

**Student:** please submit this form to physician

**Physician** please review: Health History Questionnaire, Physical Form, Immunization and TB Forms.

Does the student have an illness/condition **NOT** listed in the history, for which treatment is required?     yes     no  
 Please explain: \_\_\_\_\_

Is the student under treatment for Eating Disorder, Behavioral, OR Psychiatric Problems?     yes     no  
 Please explain: \_\_\_\_\_

Does the student have Physical Disabilities OR Assisted Devices?     yes     no  
 Please explain: \_\_\_\_\_

CLINICAL EVALUATION	NORMAL	ABNORMAL (PLEASE EXPLAIN)
<b>MEDICAL:</b>		
BP _____ T _____ P _____ R _____		
Height _____ Weight _____		
Head, Face, Neck, and Scalp		
Visual acuity and ophthalmic exam		
Ears/Nose/Throat/Sinuses/Mouth		
Lungs and Chest		
Heart		
Abdomen		
Skin		
Neurological		
G-U		
Menstrual History		
<b>MUSCULOSKELETAL:</b>		
Neck		
Back/Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
<b>REQUIRED FOR ATHLETES:</b>		
Heart Murmur*		
Femoral Pulses to exclude Aortic Coarctation		
Physical Stigmata or Marfan Syndrome		
Bilateral, Brachial Artery BP, Sitting position**		

\*Should be done supine and standing (or Valsalva Maneuver) to identify (L) Ventricular outflow obstruction

\*\*Preferably done in both arms

Physical Form Part 2

Name: \_\_\_\_\_ Start Term: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

**Student:** please submit this form to physician

**Physician** please review: Health History Questionnaire, Physical Form, Immunization and TB Forms.

NCAA SPORTS/COLLEGE INTRAMURAL CLEARANCES

ATTENTION PROVIDERS!!

- For the student to tryout/ participate in NCAA Athletics/ Intramural Activities, the **SIGNATURE SECTION MUST BE COMPLETED AND SIGNED** by the Health Care Provider (Physician, PA-C OR Nurse Practitioner).

**CLEARED**

**CLEARED**, with recommendation(s) for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOT CLEARED** for the following types of sports/intramurals (please check those that apply:)

- Contact
- Non-Contact
- Strenuous Activities

Due to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recommendation(s) / Referral(s) \_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE SECTION – Required for ALL students**

I certify that I have examined this student; that the above statements and health history are correct; and that I find the student is neither mentally nor physically disqualified by reason of communicable disease or any chronic or acute defect from successful performance as a college student at Bryn Athyn College, except as noted. Furthermore, the student is also cleared/not cleared as stated above for participation in NCAA sports/ college intramural activities.

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Print Name of Health Care Provider

\_\_\_\_\_  
Date of CIPPE



BRYN ATHYN  
COLLEGE



FOUNDED IN 1877

**Bryn Athyn College Health Services**

900 Campus Drive, Box 915, Bryn Athyn, PA 19009

Phone: 267-502-6077 | Fax: 267-502-6024

[www.brynathyn.edu/health](http://www.brynathyn.edu/health)